FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046078

Facility Name: Countryview Terrace

Address: R.R. Box 195 (Number) Louisville (City) 62858 (Zip Code)

County: Clay

Telephone Number: (618) 686-4542 **Fax #** (618) 686-2179

IDPA ID Number: 3713463060001

Date of Initial License for Current Owners: 02/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,540			5,540	13
14	TOTALS	5,540			5,540	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.86%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	24,706	1,675	52	26,433		26,433	39	26,472			1
2	Food Purchase		14,252		14,252		14,252		14,252			2
3	Housekeeping		1,833		1,833		1,833		1,833			3
4	Laundry		610		610		610		610			4
5	Heat and Other Utilities			10,267	10,267		10,267	105	10,372			5
6	Maintenance	5,626	11,449	635	17,710		17,710	446	18,156			6
7	Other (specify):*											7
8	**TOTAL General Services**	30,332	29,819	10,954	71,105		71,105	590	71,695			8
	B. Health Care and Programs											
9	Medical Director			4,939	4,939		4,939		4,939			9
10	Nursing and Medical Records	115,893	888	64	116,845		116,845		116,845			10
10a	Therapy											10a
11	Activities		168		168		168		168			11
12	Social Services	17,805	54		17,859		17,859		17,859			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	133,698	1,110	5,003	139,811		139,811		139,811			16
	C. General Administration											
17	Administrative	47,078		26,319	73,397		73,397	(26,319)	47,078			17
18	Directors Fees											18
19	Professional Services			5,309	5,309		5,309	2,460	7,769			19
20	Dues, Fees, Subscriptions & Promotions			547	547		547	54	601			20
21	Clerical & General Office Expenses	4,915	376	67,471	72,762		72,762	(45,010)	27,752			21
22	Employee Benefits & Payroll Taxes			38,431	38,431		38,431	3,047	41,478			22
23	Inservice Training & Education							76	76			23
24	Travel and Seminar							259	259			24
25	Other Admin. Staff Transportation			3,352	3,352		3,352	276	3,628			25
26	Insurance-Prop.Liab.Malpractice			18,272	18,272		18,272	134	18,406			26
27	Other (specify):*											27
28	**TOTAL General Administration**	51,993	376	159,701	212,070		212,070	(65,023)	147,047			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	216,023	31,305	175,658	422,986		422,986	(64,433)	358,553			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Countryview Terrace #0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			19,239	19,239		19,239	4,713	23,952			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			35,886	35,886		35,886	1,783	37,669			32
33	Real Estate Taxes			4,470	4,470		4,470		4,470			33
34	Rent-Facility & Grounds							500	500			34
35	Rent-Equipment & Vehicles							98	98			35
36	Other (specify):*											36
37	TOTAL Ownership			59,595	59,595		59,595	7,094	66,689			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,820	29,820		29,820		29,820			42
43	Other (specify):* Nonallowable Costs			441	441		441	(441)				43
44	TOTAL Special Cost Centers			30,261	30,261		30,261	(441)	29,820			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	216,023	31,305	265,514	512,842		512,842	(57,780)	455,062			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(359)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,850	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(82)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Day Training	(47,911)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,502)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(13,278)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (13,278)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (57,780)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace

ID# 0046078

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Countryview Terrace # 0046078 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	39	0	0	0	0	0	0	0	0	0	39	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	105	0	0	0	0	0	0	0	0	0	105	5
6	Maintenance	0	446	0	0	0	0	0	0	0	0	0	446	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	590	0	0	0	0	0	0	0	0	0	590	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(26,319)	0	0	0	0	0	0	0	0	0	(26,319)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,460	0	0	0	0	0	0	0	0	0	2,460	19
20	Fees, Subscriptions & Promotions	0	54	0	0	0	0	0	0	0	0	0	54	20
21	Clerical & General Office Expenses	0	2,901	0	0	0	0	0	0	0	0	0	2,901	21
22	Employee Benefits & Payroll Taxes	0	3,047	0	0	0	0	0	0	0	0	0	3,047	22
23	Inservice Training & Education	0	76	0	0	0	0	0	0	0	0	0	76	23
24	Travel and Seminar	0	259	0	0	0	0	0	0	0	0	0	259	24
25	Other Admin. Staff Transportation	0	276	0	0	0	0	0	0	0	0	0	276	25
26	Insurance-Prop.Liab.Malpractice	0	134	0	0	0	0	0	0	0	0	0	134	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(17,112)	0	0	0	0	0	0	0	0	0	(17,112)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(16,522)	0	0	0	0	0	0	0	0	0	(16,522)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Countryview Terrace # 0046078 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,850	863	0	0	0	0	0	0	0	0	0	4,713	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,783	0	0	0	0	0	0	0	0	1,783	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	500	0	0	0	0	0	0	0	0	500	34
35	Rent-Equipment & Vehicles	0	0	98	0	0	0	0	0	0	0	0	98	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	3,850	863	2,381	0	0	0	0	0	0	0	0	7,094	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(441)	0	0	0	0	0	0	0	0	0	0	(441)	43
44	**TOTAL Special Cost Centers**	(441)	0	0	0	0	0	0	0	0	0	0	(441)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,409	(15,659)	2,381	0	0	0	0	0	0	0	0	(9,869)	45

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100%	See Attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Companies	0.00%	$ 39	$ 39	1
2	V	5	Utilities		Petersen Health Care Companies	0.00%	105	105	2
3	V	6	Maintenance supplies		Petersen Health Care Companies	0.00%	446	446	3
4	V	17	Administrative	26,319	Petersen Health Care Companies	0.00%		(26,319)	4
5	V	19	Professional services		Petersen Health Care Companies	0.00%	2,460	2,460	5
6	V	20	Dues, fees & subscriptions		Petersen Health Care Companies	0.00%	54	54	6
7	V	21	Clerical & general office		Petersen Health Care Companies	0.00%	2,901	2,901	7
8	V	22	Employee benefits		Petersen Health Care Companies	0.00%	3,047	3,047	8
9	V	23	Inservice training & education		Petersen Health Care Companies	0.00%	76	76	9
10	V	24	Travel & seminar		Petersen Health Care Companies	0.00%	259	259	10
11	V	25	Other admin. staff transport		Petersen Health Care Companies	0.00%	276	276	11
12	V	26	Insurance-property & liab.		Petersen Health Care Companies	0.00%	134	134	12
13	V	30	Depreciation		Petersen Health Care Companies	0.00%	863	863	13
14	Total			$ 26,319			$ 10,660	$ * (15,659)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	Petersen Health Care Companies	0.00%	$ 1,783	$ 1,783	15
16	V	34	Rent-facility & grounds		Petersen Health Care Companies	0.00%	500	500	16
17	V	35	Rent-equipment & vehicles		Petersen Health Care Companies	0.00%	98	98	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 2,381	$ * 2,381	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
Provider # 0046078
12/31/2003

Schedule 6A

VII Related Parties - Page 6

Note: All 100% owned by Mark Petersen.

Related Nursing Homes	City	
In-State:		
Arcola Health Care Center	Arcola, IL	
Bement Health Care Center	Bement, IL	
Countryview Terrace	Louisville, IL	
Eastview Terrace	Sullivan, IL	
Havana Health Care Center	Havana, IL	
Kewanee Care Home	Kewanee, IL	
Palm Terrace of Mattoon	Mattoon, IL	
Prairie Rose Health Care Center	Pana, IL	
Robings Manor Nursing Home	Brighton, IL	
Royal Oaks Care Center	Kewanee, IL	
Sullivan Health Care Center	Sullivan, IL	
Sunset Manor Nursing Home	Canton, IL	
Out-of-State:		
Meadow Lawn Nursing Center	Davenport, IA	
Related Assisted Living		
Courtyard Estates	Kewanee, IL	
Other Related Business Entities		
Petersen Health Care Companies	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	100%	346,303	1	2.50	Salary	$ 6,197	L17, C1	1
2											2
3											3
4											4
5											5
6											6
7		See Attached Schedule 7A									7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,197		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Countryview Terrace
Provider # 0046078
12/31/2003

Schedule 7A

VII Related Parties
C Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Eastview Terrace	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	Total Other Centers	Countryview Terrace	TOTAL
Mark Petersen	37,699	23,276	22,462	32,710	28,962	25,443	34,589	35,181	26,725	28,388	9,151	41,717	346,303	6,197	352,500

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Patient Days	315,110	13	$ 2,200	$	5,540	$ 39	1
2	5	Utilities	Patient Days	315,110	13	5,963		5,540	105	2
3	6	Maintenance supplies	Patient Days	315,110	13	25,373		5,540	446	3
4	17	Administrative	Patient Days	315,110	13			5,540	0	4
5	19	Professional services	Patient Days	315,110	13	139,914		5,540	2,460	5
6	20	Dues, fees & subscriptions	Patient Days	315,110	13	3,044		5,540	54	6
7	21	Clerical & general office	Patient Days	315,110	13	165,031		5,540	2,901	7
8	22	Employee benefits	Patient Days	315,110	13	173,328		5,540	3,047	8
9	23	Inservice training & education	Patient Days	315,110	13	4,328		5,540	76	9
10	24	Travel & seminar	Patient Days	315,110	13	14,743		5,540	259	10
11	25	Other admin. staff transport	Patient Days	315,110	13	15,681		5,540	276	11
12	26	Insurance-property & liab.	Patient Days	315,110	13	7,635		5,540	134	12
13	30	Depreciation	Patient Days	315,110	13	49,093		5,540	863	13
14	32	Interest	Patient Days	315,110	13	101,410		5,540	1,783	14
15	34	Rent-facility & grounds	Patient Days	315,110	13	28,419		5,540	500	15
16	35	Rent-equipment & vehicles	Patient Days	315,110	13	5,568		5,540	98	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 741,730	$		$ 13,041	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank		X	Mortgage	$649 plus int.	08/31/02	$ 479,263	$ 468,823	08/31/07	Varies	$ 33,272	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Nick Adkins Brokerage		X	Commission Note	$284.00	09/10/96	225,000	7,912	08/10/06	0.0900	725	6
7	LaSalle Bank		X	Line of Credit	Interest Only	08/31/02	54,387		08/31/03	Varies	1,889	7
8												8
9	TOTAL Facility Related				$284.00		$ 758,650	$ 476,735			$ 35,886	9
	B. Non-Facility Related*											
10												10
11	Allocated From Home Office										1,783	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,783	14
15	TOTALS (line 9+line14)						$ 758,650	$ 476,735			$ 37,669	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		$ 4,540	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$ 4,510	2
3. Under or (over) accrual (line 2 minus line 1).		$ (30)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 4,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 4,470	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	4,260	8
	1999	4,361	9
	2000	4,508	10
	2001	4,508	11
	2002	4,510	12

2002 Tax Bill:	4510
Est. Increase:	-10
Est. Accrual:	4500

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Countryview Terrace COUNTY Clay

FACILITY IDPH LICENSE NUMBER 0046078

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-15-100-030	SEC 15-5-6-PT SE NW S&W of	$	$
2.		OLD US 45 - 7.63 AC	$ 4,510.00	$ 4,510.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 4,510.00	$ 4,510.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 4,416 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	402,930	1996	$ 10,000	1
2					2
3	TOTALS	402,930		$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1996	1976	$ 579,889	$ 14,868	35	$ 16,568	$ 1,700	$ 132,418	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Survey			1996	1,700		20	85	85	652	9
10	Curtains			1996	307	31	20	15	(16)	113	10
11	Pump Repairs			1996	1,163		20	58	58	450	11
12	Repiping Water Heater			1996	1,681		20	84	84	637	12
13	Fence			1997	2,469	90	20	123	33	769	13
14	Plumbing			1997	1,234		20	62	62	413	14
15	Handicapped Showers & Ramp			1998	1,962	50	20	98	48	539	15
16	Landscaping			2000	4,289	286	20	214	(72)	749	16
17	Drainage and Sidewalk			2001	2,557	85	20	128	43	321	17
18	Roof			2001	8,702	290	20	435	145	1,088	18
19	Water Supply			2002	2,412	62	20	121	59	242	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 608,365	$ 15,762		$ 17,991	$ 2,229	$ 138,391	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 38,240	$ 2,431	$ 3,824	$ 1,393	10	$ 27,069	71
72	Current Year Purchases	526	44	26	(18)	10	26	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			863	863			74
75	TOTALS	$ 38,766	$ 2,475	$ 4,713	$ 2,238		$ 27,095	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident use	1995 Dodge Maxivan	1999	$ 9,986	$ 1,002	$ 1,248	$ 246	5	$ 6,240	76
77										77
78										78
79										79
80	TOTALS			$ 9,986	$ 1,002	$ 1,248	$ 246		$ 6,240	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 667,117	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 19,239	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 23,952	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,713	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 171,726	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		Allocated from Home Office			500			5
6								6
7	TOTAL				$ 500 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 98 Description: Allocated from Home Office - 98
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care	N/A	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Countryview Terrace
Provider #: 0046078
01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	86,749	86,749	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,082	2,082	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	116,121	116,121	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 204,952	$ 204,952	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	14,169	10,000	13
14	Buildings, at Historical Cost	600,118	608,365	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	48,752	48,752	16
17	Accumulated Depreciation (book methods)	(164,916)	(171,726)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 498,123	$ 495,391	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 703,075	$ 700,343	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,467	$ 46,467	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	7,228	7,228	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	4,500	4,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached schedule 17A	17,074	17,074	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 75,269	$ 75,269	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,912	7,912	39
40	Mortgage Payable	468,823	468,823	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 476,735	$ 476,735	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 552,004	$ 552,004	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 151,071	$ 148,339	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 703,075	$ 700,343	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

FACILITY NAME Countryview Terrace
PROVIDER # 00041715
12/31/2003

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule 17A

XV. BALANCE SHEET - Unrestricted Operating Fund.

C. Current Liabilities

Other Current Liabilities (specify):	Operating	After Consolidation
Due to Due from	2,529	2,529
Due to Patients	12,328	12,328
Assessments	(8,882)	(8,882)
Accrued Vacation	7,712	7,712
Acc Ins - Gen	1,285	1,285
Accrued Expenses - Other	2,102	2,102
Total Line 36 - Other Current Liabilities(specify):	**17,074**	**17,074**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 140,248	1	
2	Restatements (describe):		2	
3	**Prior period adjustment**	(8,122)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 132,126	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	18,945	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 18,945	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 151,071	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 531,787	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 531,787	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 531,787	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	71,105	31
32	Health Care	139,811	32
33	General Administration	212,070	33
	B. Capital Expense		
34	Ownership	59,595	34
	C. Ancillary Expense		
35	Special Cost Centers	441	35
36	Provider Participation Fee	29,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 512,842	40
41	**Income before Income Taxes (line 30 minus line 40)****	18,945	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 18,945	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
Entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	14,239	14,709	115,893	7.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	1,840	1,936	17,805	9.20	11
12	Dietician					12
13	Food Service Supervisor	2,282	2,406	24,706	10.27	13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	660	660	5,626	8.52	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,781	1,861	40,881	21.97	20
21	Assistant Administrator					21
22	Other Administrative	37	37	6,197	167.49	22
23	Office Manager	268	268	4,058	15.14	23
24	Clerical	21	21	857	40.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	21,128	21,898	$ 216,023 *	$ 9.86	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	4,939	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	2 visits	64	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 5,003		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Miranda Wattles	Administrator	0	$ 40,881
Allocated from Home Office			
Mark Petersen	Administrative	100%	6,197
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 47,078

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Column 7)	$ 26,319
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 26,319

C. Professional Services

Vendor/Payee	Type	Amount
Bush, Snyder & Associates	Legal	$ 113
Altschuler, Melvoin and Glasser, LLP	Accounting services	3,755
America Online	Internet services	299
ADP	Payroll services	1,074
Rudy Hadsell	Operation consulting	68
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 5,309

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 6,666
Unemployment Compensation Insurance	2,082
FICA Taxes	15,058
Employee Health Insurance	11,835
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	1,941
Retirement	129
Employee Morale	720
Home Office Allocation	3,047
TOTAL (agree to Schedule V, line 22, col.8)	$ 41,478

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	97
Health Care Worker Background Check	
(Indicate # of checks performed 5)	60
License & permits	390
Home Office Allocation	54
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 601

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	259
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 259

* Attach copy of IMRF notifications

**See instructions.

Countryview Terrace
Provider #: 0046078
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	5,309
Allocated from Management Company	
Professional Services - Legal	338
Professional Services - Other	2,122
Total (agree to Schedule V, line 19, column 8)	7,769

See Accountants' Compilation Report

Facility Name & ID Number Countryview Terrace # 0046078 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6			N/A										
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Countryview Terrace # 0046078 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A

(3) Did the nursing home make political contributions or payments to a politica action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ None Line N/A

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 29,820
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $ N/A

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in progress

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Countryview Terrace** **11:34 AM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-57,780	equal to	-57,780	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	37,669	equal to	37,669	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	4,470	equal to	4,470	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	23,952	equal to	23,952	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	500	equal to	500	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	98	equal to	98	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	71,105	equal to	71,105	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	139,811	equal to	139,811	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	212,070	equal to	212,070	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	59,595	equal to	59,595	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	441	equal to	441	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	29,820	equal to	29,820	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	115,893	equal to	115,893	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to		0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,805	equal to	17,805	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	24,706	equal to	24,706	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	5,626	equal to	5,626	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to		0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	47,078	equal to	47,078	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	4,915	equal to	4,915	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	216,023	equal to	216,023	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	52	-52	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,939	< or = to	4,939	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	64	< or = to	64	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	47,078	equal to	47,078	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	26,319	equal to	26,319	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	5,309	equal to	5,309	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	41,478	equal to	41,478	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	601	equal to	601	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	259	equal to	259	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	29,820	equal to	29,820	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	3,047	-3,047	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-13,278	equal to	-13,278	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	476,735	equal to	476,735	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	4,500	equal to	4,500	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	10,000	equal to	10,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	608,365	equal to	608,365	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	48,752	equal to	48,752	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	171,726	equal to	171,726	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	151,071	equal to	151,071	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	18,945	equal to	18,945	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	703,075	equal to	703,075	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!! 11/04/05 11:34:34 AM

HSA Number	5	Name	Countryview Terrace		
Cost report period	From:	01/01/03	To:	12/31/03	Base Number 336
If this is an ICF/DD 16 facility, enter a 1 in cell C		N			
Licensed bed days:	5,840	Occupancy:	5,540	Pct. of occupancy:	94.86%
Illinois Public Aid Support Rat		$			

Genl Services Salary/Wage:	30,332	Col 1, Line 8 ---Audit Adj:	
Genl Admin Salary/Wage	51,993	Col 1, Line 28 ---Audit Adj	-6197
Total Salary Wage	216,023	Col 1, Line 44 ---Audit Adj	-6197
Employee Benefits	41,478	Col 8, Line 22 ---Audit Adj	
Total General Services:	71,695	Col 8, Line 8 ---Audit Adj:	
Total General Admin	147,047	Col 8, Line 28 ---Audit Adj	-6197

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amou out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amou by this proportion to get the fringe amoun for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$30,332
Divided by Total Wages (Column 1, Line 44	$209,826
General service wages as percent of total wages	14.4558%
Employee Benefits (Column 10, Line 22	$41,478
Allocation of Employee Benefits to General Services Costs	$5,996
Plus Total General Services (Column 10, Line 8	$71,695
New Total General Services Cost	$77,691

B. General Administration

1 Determine the proportion of General Administratio wages to total wages.

2 Multiply the total lump sum fringe amount by th proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your tota General Administration expenses

4 Subtract the total lump sum fringe amount from you General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$45,796
Divided by Total Wages (Column 1, Line 45	$209,826
General administration wages as a percent of total wages	21.8257%
Employee Benefits (Column 10, Line 22	$41,478
Allocation of Emplayee Benefits to General Admin. Cost	$9,053
Plus Total General Administration (Column 10, Line 2	$140,850
Minus Total Fringe (Column 10, Line 2:	$41,478
New Total General Administration Cos	$108,425

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflatior fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To selec the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select th inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculatior

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find th multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (fron Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$77,691	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$77,691

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$108,425	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$108,425
3 Total Updated Support Costs (1 + 2		$186,116

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $33.59

A. If the occupancy (Cost Report, Page 2, Schedule III-C) i equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patien days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$186,116
Total Patient Days (Cost Report	5,540
Support Costs per Dier	$33.59

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patier days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	5,840
Multiplied by	0.93
	5,431
Minus total Patient Day	5,540
	-109
One-third of difference	-36
Plus Total Patient Day	5,540
Adjusted Occupancy	5,504
Total Support Costs (Step II, C, 3, above	$186,116
Divided by Adjusted Occupany	5504
Support Costs Per Dien	$33.81

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75t percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to c greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to o greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$32.69
Minus Support Costs Per Dier	$33.59
Difference	-$0.90
Multiply the Difference by	0.5
One-Half of the Difference	-$0.45
Plus Support Costs Per Dier	$33.59
Support Rate if costs are between 35th and 75th percentile	33.14

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$32.69
Minus Support Costs Per Dier	$33.59
Difference	-$0.90
Multiply the Difference by	0.5
One-Half of the Difference	-$0.45
Compare one-half the difference to the profit ceiling for your HSA in Table II anc	2.63
Enter the Lower of the Two Amounts	-$0.450
Plus Support Costs Per Dier	$33.59
Support Rate if support costs less than 35th percentile	$33.14

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **$32.69**

75th Percentile is	$32.69
35th Percentile is	$27.53

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceilinc
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceilinc
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/04/05 11:34:34 AM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Countryview Terrace** ID: **0046078**

HSA No.: ? Own or Rent? (O or R) ____ Own or Rent Beginning: ____

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	16	Total Patient Days	5,540
Begin	**01/01/03**	Licensed Bed Days:	5,840	% Occupied	94.86%
End	**12/31/03**			Capital Days	5,540

1989 Property Tax COST: ____ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ____ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ____ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1977
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	608365
2. Total licensed beds from cost report Page 2, Line 7, column 3	16
3. Line 1 divided by Line 2	$38,023
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)		0
2. Divided by: Capital Days (see below)		5,540
3. Equals: Per Diem Cost		$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A	
5. Equals: Updated Property Tax Cost	#N/A	

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	5,540
2. Total Licensed Bed Days * .93	5431
3. Capital Days (higher of Line 1 or Line 2)	5,540

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	76	579889	44071564	12
2	2	0	0	0	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	96	1700	163200	12
7	7	96	307	29472	12
8	8	96	1163	111648	12
9	9	96	1681	161376	12
10	10	97	2469	239493	12
11	11	97	1234	119698	12
12	12	98	1962	192276	12
13	13	100	4289	428900	12
14	14	101	2557	258257	12
15	15	101	8702	878902	12
16	16	102	2412	246024	12
17	17	0	0	0	12
18	18	0	0	0	12
19	19	0	0	0	12
20	20	0	0	0	12
21	21	0	0	0	12
22	22	0	0	0	12
23	23	0	0	0	12
24	24	0	0	0	12
25	25	0	0	0	12
26	26	0	0	0	12
27	27	0	0	0	12
28	28	0	0	0	12
29	29	0	0	0	12
30	30	0	0	0	12
31	31	0	0	0	12
32	32	0	0	0	12
33	33	0	0	0	12
34	34	0	0	0	12A
35	35	0	0	0	12A
36	36	0	0	0	12A
37	37	0	0	0	12A
38	38	0	0	0	12A
39	39	0	0	0	12A
40	40	0	0	0	12A
41	41	0	0	0	12A
42	42	0	0	0	12A
43	43	0	0	0	12A
44	44	0	0	0	12A
45	45	0	0	0	12A
46	46	0	0	0	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

46900810 608365 77.09320885

Base Year = 1977

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	24,706	1,675	52	26,433	0	26,433	39	26,472
2. Food Purchase	0	14,252	0	14,252	0	14,252	0	14,252
3. Housekeeping	0	1,833	0	1,833	0	1,833	0	1,833
4. Laundry	0	610	0	610	0	610	0	610
5. Heat and Other Utilities	0	0	10,267	10,267	0	10,267	105	10,372
6. Maintenance	5,626	11,449	635	17,710	0	17,710	446	18,156
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	30,332	29,819	10,954	71,105	0	71,105	590	71,695
9. Medical Director	0	0	4,939	4,939	0	4,939	0	4,939
10. Nursing & Medical Records	115,893	888	64	116,845	0	116,845	0	116,845
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	0	168	0	168	0	168	0	168
12. Social Services	17,805	54	0	17,859	0	17,859	0	17,859
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	133,698	1,110	5,003	139,811	0	139,811	0	139,811
17. Administrative	47,078	0	26,319	73,397	0	73,397	-26,319	47,078
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,309	5,309	0	5,309	2,460	7,769
20. Fees, Subscriptions & Promotion	0	0	547	547	0	547	54	601
21. Clerical & General Office	4,915	376	67,471	72,762	0	72,762	-45,010	27,752
22. Employee Benefits & Payroll	0	0	38,431	38,431	0	38,431	3,047	41,478
23. Inservice Training & Education	0	0	0	0	0	0	76	76
24. Travel and Seminar	0	0	0	0	0	0	259	259
25. Other Admin. Staff Trans	0	0	3,352	3,352	0	3,352	276	3,628
26. Insurance-Prop.Liab.Malpractice	0	0	18,272	18,272	0	18,272	134	18,406
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	51,993	376	159,701	212,070	0	212,070	-65,023	147,047
29. Total General Administrative	216,023	31,305	175,658	422,986	0	422,986	-64,433	358,553
30. Depreciation	0	0	19,239	19,239	0	19,239	4,713	23,952
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	35,886	35,886	0	35,886	1,783	37,669
33. Real Estate	0	0	4,470	4,470	0	4,470	0	4,470
34. Rent - Facility & Grounds	0	0	0	0	0	0	500	500
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	98	98
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	59,595	59,595	0	59,595	7,094	66,689
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	29,820	29,820	0	29,820	0	29,820
43. Other (specify):*	0	0	441	441	0	441	-441	0
44. Total Special Cost Ce	0	0	30,261	30,261	0	30,261	-441	29,820
45. Grand Total	216,023	31,305	265,514	512,842	0	512,842	-57,780	455,062

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	86,749	86,749
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	2,082	2,082
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	116,121	116,121
9. Other (specify):	0	0
10. Total current assets	204,952	204,952
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	14,169	10,000
14. Buildings, at Historical Cost	600,118	608,365
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	48,752	48,752
17. Accumulated Depreciation (book methods)	-164,916	-171,726
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	498,123	495,391
25. Total Assets	703,075	700,343
CURRENT LIABILITIES		
26. Accounts Payable	46,467	46,467
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	7,228	7,228
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	4,500	4,500
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	17,074	17,074
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	75,269	75,269
LONG TERM LIABILITES		
39.Long-Term Notes Payable	7,912	7,912
40.Mortgage Payable	468,823	468,823
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	476,735	476,735
46.Total Liabilities	552,004	552,004
47.Total Equity	151,071	148,339
48.Total Liabilities and Equity	703,075	700,343

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	531,787
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	531,787
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	-
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	531,787
31. General Services	71,105
32. Health Care	139,811
33. General Administration	212,070
34. Ownership	59,595
35. Special Cost Centers	441
35. Provider Participation Fee	29,820
37. Other	0
40. Total Expenses	512,842
41. Income Before Income Taxes	18,945
42. Income Taxes	0
43. Net Income or Loss for the Year	18,945

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23	Provider Participation fee is linked from page 4